Exhibit 2a

BP-S620.060 PATIENT PROBLEM LIST COFRM AUG 96

П.	S.	DEPARTMENT	OF	TITOMTOR.
(a)	- a	TATELLY TATELLY T		UUDULLE

FEDERAL BUREAU OF PRISONS

DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE
16/97	MOSTD-TX'	(R) Hand Fx + Sx	1992
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	Ap. magazin		
	ADVERSE / ALLER DRUG REACTIONS (If none, recor	GIC rd শNo Known Drug Allergies)	
NKDA			
7		The state of the s	

(Name, Reg #, DOB)

DEMETRIUS 21534-039

CUSTODY/IN

B/M/O/02-08-1972 HT/509 WT/170 HR/BK EY/BN

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	PROBLEM	LIST (Continued)	
DATE NOTED	SIGNIFICANT DIAGNOSES	SIGNIFICANT OPERATIONS/ INVASIVE PROCEDURES	DATE
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Patient identification (Name, Reg #, DOB)

BP-S619.060 IMMUNIZATION RECORD CDFRM

AUG 96

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

				TETANUS	TOXOIDS		
DATE	MFG'R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION
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7-8-98	omancht	2486-11	10-99	DEA	574 ID	FCI Mckean	7-10-98	0,00	Gart
1/1/99	Converse	2493-11	1/12/00	WEA	574 ZD	C. Riman & Fei mcha	1/9/99	010	Mine
1/11/10	conceded	10149 AA	9/17/0	DEA	5 54 IS	e Riger An	7/13/00	0X0	Rut
7/07/01	Comen	C0630AA	5/15/02	(DFA	0,1cc	ECT MCKean	7/11/01	0 X 6	20
19/02 4	Arestisco	194 AB	8/16/040	DA	0./60	F61978 18890	27/11/02	OXOV	an
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129/04	In Sedale	00/54P	08/05	LT. Am	Ofer I	o mhen	11101	0 <	
10/27/04	Aleutis	C31/4.4B	(19/07	CFA	OUID	Liter to IRBK	18/29/	SU der	m.
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Patient Identification (Name, Reg #)

DEMETRIUS

CUSTODY/IN

21534-039

B/M/O/02-08-1972

HT/509 WT/170 HR/BK

EY/BN

000003

				HEPATITIS	VACCINE		
DATE	MFG · R	LOT #	EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION

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	T			INFLUENZA	···		
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DATE	MFG'R	LOT #	EXP.		DOSE/	PROVIDER	INSTITUTION
DATE	MFG ' R	LOT #	EXP.		DOSE/	PROVIDER	INSTITUTION
DATE	MFG ' R	LOT #	EXP.		DOSE/	PROVIDER	INSTITUTION
DATE	MFG'R	LOT #	EXP.		DOSE/	PROVIDER	INSTITUTION
DATE	MFG ' R		EXP.		DOSE/	PROVIDER	INSTITUTION
DATE	MFG ' R		EXP.		DOSE/	PROVIDER	INSTITUTION
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DATE	MFG'R		EXP.		DOSE/	PROVIDER	INSTITUTION
DATE	MFG ' R		EXP. DATE	SITE	DOSE/ ROUTE	PROVIDER	INSTITUTION
DATE	MFG'R		EXP. DATE		DOSE/ ROUTE	PROVIDER	INSTITUTION

Patient Identification (Name, Reg 孝)

MEDICAL RECORD		REPORT	OF I	MEDI	CAL EXAMI	NATION	and the second s	DATE OF EXAM	vi 1. · · · ·
1. LAST NAME-FIRST NAME-MIDDLE	VΔME		marane de se ba	(2 (5	ENTIFICATION NU	ACCD		4/851	الات
1. Exp 14 Maria 14 Ma	'ች _	- Lian -		2. 10	~		3. GRADE AND O	COMPONENT OR PO	NOITIZE
4. HOME ADDRESS (Number, street or I	Den	cervuis			21534	239			
4. HOWE ADDRESS (Number, Street or I	CODAM DE LOW	n, state and ZIP code) J		5. EM	ERGENCY CONTAC	// **	_		
16134 0	i con co						warda.	,	
Defroit,	MI.	18219				L24329	Leewin	/	
				<u> </u>		Detroct	, M. 4	824	
6. DATE OF BIRTH	7. AGE	8. SEX		9. REI	ATIONSHIP OF CO	NTACT	,		
2/8/12	31	FEMALE MA	ALE .	<u> </u>		L,			
10. PLACE OF BIRTH		11. RACE			AS 4EDICA N. INC.				
Defroit, MT.		WHITE X BL	ACK		AMERICAN INDIAN ALASKA NATIVE	HISPAN WHITE	IC HISPANIC BLACK	ASIAN/PACIF	HC
12a. AGENCY	_	12b. ORGANIZATION UNI	Υ			13. T	OTAL YEARS GOVE	RNMENT SERVICE	
B0700	J	F(Ol Mc	Kean		a, MILITARY	b.	CIVILIAN	
14. NAME OF EXAMINING FACILITY OR	EXAMINER, AN	D ADDRESS		15. RA	TING OR SPECIAL	TY OF EXAMINER	<u> </u>		
		. Car 311		40.00		·	· · · · · · · · · · · · · · · · · · ·		
	P. C). Box 5000		16. PU	RPOSE OF EXAMIN	,			
	Bri	edford, PA 16701				1 Days	. Ni		
						+ Anue	414		
		17. CL	INCIA	L EVA	LUATION		,		
NOR- MAL (Check each item in appropria	ite column, ente	r "NE" if not evaluated.)	ABNOR MAL	NOR MAL	(Check each ite	m in appropriate	column, enter "NE" .	if not evaluated.)	A8NOF MAL
A. HEAD, FACE, NECK AND SCAL				NIS	O. PROSTATE (Ov	er 40 or clinically	indicated)		ì
B. EARS-GENERAL (INTERNAL CA	ANALS)	ent Ceremen		1	P. TESTICULAR				
(Auditory acui	ty under items 3	'9 and 40)		Me	Q. ANUS AND REC	TUM (Hemorrhoi	ds, Fistulae) (Hemod	cult Results)	
C. DRUMS (Perforation) TM	12 Inter	of fld.		اسا	R. ENDOCRINE SY:	STEM			
UD. NOSE (f) DNS -	RT	,		1	S. G-U SYSTEM				
LE. SINUSES	А	n ,		4	T. UPPER EXTREM	ITIES (Strength, r	ange of motion)		
C F. MOUTH AND THROAT (#)	Tonils	1+ Smoth		U	U. FEET				1
G. EYES-GENERAL (Visual acuity a	nd refraction un	der items 28, 29, and 36)		4	V. LOWER EXTREM	AITIES (Except fee	et) (Strength, range	of motion)	1
(H. OPHTHALMOSCOPIC				4	W. SPINE, OTHER	MUSCULOSKELE	TAL		1
1. PUPILS (Equality and reaction)				U	X. IDENTIFYING BO	DDY MARKS, SCA	RS, TATTOOS		
J. OCULAR MOTILITY (Associated	parallel movem	ents nystagmus)			Y. SKIN, LYMPHAT	ics			
C R. LUNGS AND CHEST				1/	Ž. NEUROLOGIC (Equilibrium tests	under item 41)		1
C. HEART (Thrust, size, rhythm, so	unds)			L	AA. PSYCHIATRIC	(Specify any person	onality deviation)		
M. VASCULAR SYSTEM (Varicosit	ies, etc.)				BB. BREASTS				_
/ N. ABDOMEN AND VISCERA (Incl	ude hernia)	· · · · · · · · · · · · · · · · · · ·			CC. PELVIC (Fema	iles only)			_
NOTES: (Describe every abnormality in de	tail. Enter perti	nent item number before es	ch com	ment. C	Continue in item 42	and use addition	al sheets if necessa	evl	
Nech- Fr	om, {	SLA, E	T	m'.) , \$ \b	rulS'	CC)P _Y	
18. DENTAL (Place appropriate symbols, s		x 2 3 Missing X 1	X X 2 3	er and lo Replace by Denture 13	$d = \frac{(\begin{array}{c} X \\ 1 \\ 2 \\ 3 \\ 3 \\ 3 \\ 3 \\ 3 \\ 3 \\ 3 \\ 3 \\ 3$	Fixed Partial entures L E F	REMARKS AND A DEFECTS AND DIS	ODITIONAL DENTA SEASES	L
	19 TFC	F RESULTS (Copies	né ro-	ulto -	ra neoŝo	- at-a-t	~ \		
LIBINALYSIS- /1) Specific GRAVITY	13,163	resucts (copies			re preferred as TX-RAY OR PPD //				
A. URINALYSIS: (1) SPECIFIC GRAVITY	(4) MICRO	SCOPIC		🕠 11. 0	oltrop	resc, upie, min n	umber and result)		
2) URINE ALBUMIN		22710	İ				•	0000-	
3) URINE SUGAR . SYPHILIS SEROLOGY (Specify test used	D. EKG	E. BLOOD TYPE AND	Ru I	EOTUE	Q TESTS		U	00005	
and results)	J . E.NO	FACTOR	(01 1	i. UTHE	RITESTS				

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SETTING	138	RECUM- SYS.		C. STANDING	SYS.	A. SITTIN	IG B.	RECUMBENT	C. STANDING (3 mins.)	D. AFTER EX	XERCISE E	. 2 MINS. A	AFTER
DIA		BENT DIAS		(5 mins.)	DIAS.	17	t Ki	10/2	10 //////				
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LEFT 20/ 2		CORR. TO 20/		BY	S.		CX			CORR. TO		BY	
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		EXO	11.13.		L.H.		PRISM D	NV.	PRISM CONV. CT		PC		PD
32	2. ACCO	MMODATION		33. COLOR	VISION (Test	used and r	esult)			PTION	LINGORD	FOTED	***************************************
RIGHT /	L	LEFT NL			0//		•		34. DEPTH PERCE (Test used and	score)	UNCORR		
	35. FIEL	D OF VISION		36. NIGHT	VISION (Test u	sed and s	corel		37. RED LENS TES	T.	CORREC		
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					(U	lse additio	nal sheets	if necessary)					
43. SUMMARY	OF DEFE	CTS AND DIAGNO	SES (Lis	t diagnoses	with item num	bers)							
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44 DECOMMENTAL	OATION!	ELIOTUES ASSE											
44. RECOMMEN	DATION	S - FURTHER SPECI	ALIST E	XAMINATIC	NS INDICATE) (Specify,		,	0	45A	PHYSICAL	L PROFILE	
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F. IS NOT			rwy	WWW [1100	レベヘラ	7) W	1410	Weller	W			
47. IF NOT QUAL	IFIED, LI	ST DISQUALIFYING	OF/EC	TS BY ITEM	NUMBER		/ 	700	A	В	С	E	
													
48. TYPED OR PR	RINTED N	AME OF PHYSICIA	Mr.		11.		SIGNA	TURE			<u> </u>		
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49. TYPED OR PR	NTED N	AME OF PHYSICIA	N	-174	· · · / /	// <u>C</u>	SIGNA	TURE		···	UJE	7 0	
							J. GIAN	2	LØ 1	- 11/			
50. TYPED OR PRI	INTED N	AME OF DENTIST	ાની કેન	lson, MD	cate which)		Clou.	TUDE	2 W	1/1/			-
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51. TYPED OR PRI	NTED N	AME OF REVIEWIN	G OFFI	ER OR ARS	POVINIO ALSS	OP/TO	1015						-
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MEDICAL RECORD		REPORT	OF P	WED	ICAL EXAMINATION		DATE OF EXAM	゚゙゚゙゚゚゙゚゙゚゙゚ゔゔ
1. LAST NAME-FIRST NAME-MIDDLE N			innocument (signal)		DENTIFICATION NUMBER	3. GRADE AND CO		SITION
Drow		metrios			21534-039		•	
4. HOME ADDRESS (Number, street or R	2 1	ite and ZIP code)		5. Ei	MERGENCY CONTACT (Name and a	eddress of contact)		
16134 Green					Kimberly Moure	À /	A	•
Detroit, MI.	18219	Ent Sugar			16134 Greenvier	w Bet, 1	ML. 482	19
G DATE OF BIRTH ,				10.70				
2 /0/71	<u> </u>	SEX		9.7	LATIONSHIP OF CONTACT			
10/PLACE OF BIRTY	25	FEMALE / MA	LE.	<u>l'</u>	Wite			
X Dollard	r	-1 h1		i	AMERICAN INDIAN/ HISPA ALASKA NATIVE WHIT	ANIC - HISPANIC	ASIANI/PACIE	ıc
12a. AGENCY	121	WHITE BCA	ACK r			E BLACK	ASIAN/PACIF ISLANDER	
		-	•	_	a. MILITARY	TOTAL YEARS GOVER	NMENT SERVICE	
CKY-DO	-	HUT	N	\mathcal{I}	(an)	b. C	WILIAM	
14. NAME OF EXAMINING FACILITY OR E	XAMINER, AND AL	DORESS		15. F	ATING OR SPECIALTY OF EXAMIN	FR FR		
FCT	-mc	Rean			TOTAL CONTENT OF CACAMINA	CII.		
Box	5000			16. P	URPOSE OF EXAMINATION			
	()	\mathcal{L}						
$\mathcal{S}(a)$	i do	1 A			77 7			
		7 17 CU	MCIA	I FV/	ALUATION			
NOR- (Check each item in appropriat	e column, enter "N		ABNOR	·	(Check each item in appropriat	te column antar "NE" if	and overlands of t	LARNOR-
A. HEAD, FACE, NECK AND SCALE			MAL	MAL	O. PROSTATE (Over 40 or clinical	· · · · · · · · · · · · · · · · · · ·	not evaluatea.)	ABNOR-
B. EARS-GENERAL (INTERNAL CA)			 	/	P. TESTICULAR	7	15	
	under items 39 an	d 40)			Q. ANUS AND RECTUM (Hemorrh	noids. Fistulae) (Hemocu	J (
C. DRUMS (Perforation)			/		R. ENDOCRINE SYSTEM			
D. NOSE				1/	S. G-U SYSTEM			+
E. SINUSES		-			T. UPPER EXTREMITIES (Strength	, range of motion)		+
F. MOUTH AND THROAT				1	U. FEET			
G. EYES-GENERAL (Visual acuity an	d refraction under i	tems 28, 29, and 36)		1/	V. LOWER EXTREMITIES (Except I	feet) (Strength, range of	f motion)	1
H. OPHTHALMOSCOPIC				V	W. SPINE, OTHER MUSCULOSKE			
I. PUPILS (Equality and reaction)					X. IDENTIFYING 80DY MARKS, SO	CARS, TATTOOS	Tec #531	/
J. OCULAR MOTILITY (Associated p	arallel movements	nystagmus)		سما	Y. SKIN, LYMPHATICS)	
K. LUNGS AND CHEST				100	Z. NEUROLOGIC (Equilibrium tes	ts under item 41)		
L. HEART (Thrust, size, rhythm, sou.	nds)				AA. PSYCHIATRIC (Specify any per	rsonality deviation)	ルモ	
M. VASCULAR SYSTEM (Varicositie					8B. BREASTS		1,	
N. ABDOMEN AND VISCERA (Inclu			1		CC. PELVIC (Females only)		14	
NOTES: (Describe every abnormality in detail	ail. Enter pertinent	item number before ear	ch com	ment.	Continue in item 42 and use addition	onal sheets if necessary	ď	
b & C imparted	Unum	un, Tu	ÍA.	st	nsualized.			
						C	Opy	
							Te Te	
18. DENTAL (Place appropriate symbols, sh	own in examples, a	bove or below number of	of uppe	r and l	ower !eeth.)	REMARKS AND AD		-
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		STHIS ICANIA			ere preferred as attachmen		and the state of t	
A. URINALYSIS. (1) SPECIFIC GRAVITY		Testing (Cables)			ire preferred as attachmer ST X-RAY OR PPO (Place, date, film			
(2) URINE ALBUMIN	(4) MICROSCO	PIG .			In consequent way (COLO)			
(3) URINE SUGAR			approximately and			0000	AC PHY	
C. SYPHILIS SEROLOGY (Specify test used	D. akg	E. BLOOD TYPE AND	RH E	. OTH	ER TESTS	0000	<i>.</i>	
and results)		FACTOR	Ι.					

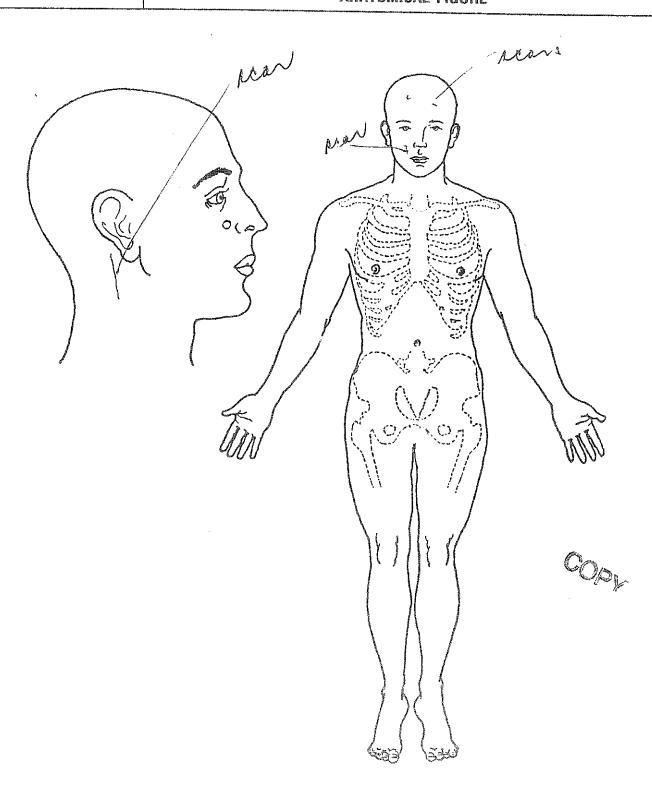
Case	4:04 d 60	579 \$y	M-SPB		OCUME REMENTS		OTHE	3 4 R FIN	iled C	ั้นได้3	/200	6	Pag	e 9 of 23
20. HEIGHT	21. WEIGHT	22. COLOR	1	COLOR		. BUILD							2	25. TEM:PERATURE
<u> </u>	174	place		بوم	27	SL	NDER		⁄JEDIU™	HE	AVY [380	SE	97-6
	BLOOD PRESSURE (· · · · · · · · · · · · · · · · · · ·				·*************************************	-		ILSE (Ari				
A. SYS. 116 SITTING DIAS. 76			DING DIAS.		A. SITTING	B. R	CUMB	ENT	C, STANDI /3 min:	ING s.)	D. AFTE	ER EXER	CISE	. 2 MINS, AFTER
***************************************	TANT VISION		-	29.	. REFRACTIC	N				Acqueration of the last of the	*****************	30. NE	AR VIS	HON
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LEFT 20/ (L) 31. HETEROPHORIA (CORR. TO 20/	BY	and de Antonomore and the Antonomore	S.		CX				(CORR. T	0		87
ESO	EXO	R.H.	L.H		p	RISM DIV	<i>t.</i>		PRISM	CONV.		1	PC	PĐ
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RIGHT	LEFT					N			(Test u	sed and	score)		ORREC	
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MEDICAL RECORD

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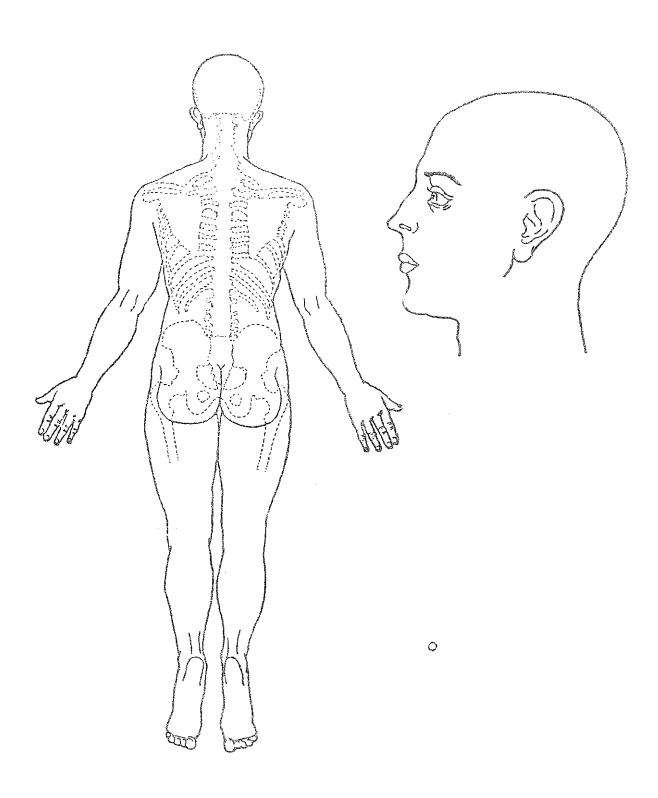


PATIENTS IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility.)

REGISTER NO,

WARD NO.

ANATOMICAL FIGURE



U.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HISTO: REPORT

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1.	LAST	NAME	-FIRST NAME-MIDDLE NAM	E			2. REGIS	TER I	NUM	BER	
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			ARE		/	/	4-19	- - C :	F	Rs,	brook
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	$\frac{\vee}{}$		ted suicide	action				<u> </u>	V		hearing aid
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	\checkmark		Scarlet fever		V		Adverse reaction to serum drug		V		Epilepsy or fits
	\checkmark		Rheumatic fever				or medicine		V		Car, train, sea or air sickness
	V		Swollen or painful joints		4		Broken bones		V		Frequent trouble sleeping
	<u> </u>		Frequent or severe headache		1		Tumor, growth, cyst, cancer		V		Depression or excessive worry
	V		Dizziness or fainting spells		V		Rupture/hernia		\checkmark	, <u>.</u>	Loss of memory or amnesia
	V		Eye trouble		V		Piles or rectal disease		V	₂	Nervous trouble of any sort
	$\sqrt{}$		Ear, nose, or throat trouble	 	4		Frequent or painful urination		V		Periods of unconsciousness
	\checkmark		Hearing loss		4		Bed wetting since age 12			_	Have you ever had
	V		Chronic or frequent colds		V		Kidney stone or blood in urine		V		homosexual contact?
	¥		Severe tooth or gum trouble		V .		Sugar or albumin in urine		V		Been exposed to AIDS
	V		Sinusitis Hay Fever	┝─┼	<u> </u>		VD—Syphilis, gonorrhea, etc.		<u> </u>		Alcohol Use (Excessive)
	\checkmark		Head injury		<u> </u>		Recent gain or loss of weight		Y	<u> </u>	Drug Use/Addiction
	V		Skin diseases				Arthritis, Rheumatism, or Bursitis Bone, joint or other deformity		V		Marijuana
-	V V		Thyroid trouble	-	\		Lameness			*****************	Cocaine Heroin
	v		Tuberculosis				Loss of finger or toe		*		L.S.D.
			Asthma		*/		Painful or "Trick"shoulder or elbow		√ √		Amphetamines
			Shortness of breath		Ť		Recurrent back pain		V		Others: (Specify)
	· park		Pain or pressure in chest		7		"Trick" or locked knee		*		odicis. (opecity)
	V		Chronic cough		V		Foot trouble		_		Alcohol or drug
			Palpitation or pounding heart		$\sqrt{}$		Neuritis			r	Withdrawal Problems
_	V .		Heart trouble		abla		Paralysis (include infantile)		<u> </u>		
	V		High or low blood pressure						\dashv		
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	$\sqrt{}$		Frequent indigestion	-							Been treated for a female disorder
	\checkmark		Stomach, liver, or intestinal trouble				,	-			Had a change in menstrual pattern
	VI.	,	Gall bladder trouble or gallstones				1000				ARE YOU PREGNANT
	-/		Jaundice or hepatitis		-			-	\dashv		SUSPECT YOU ARE PREGNANT
j. V	'HAT	OY 21	JR USUAL OCCUPATION?	······································				12. A	RE Y	OU (Che	cck one)
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-		13. Have you been refused employment or been unable to hold a	YES	NO	
		job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		V	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
	./	Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other
	1	C. Inability to assume certain positions.			than minor illnesses? (If yes, give complete address of doctor, ho clinic, and details.)
-	4	D. Other medical reasons (If yes, give reasons.)			20. Have you ever been rejected for military service because of
_ ;		14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).			physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	samurk	15. Have you ever been denied life insurance? (If yes, state reason and give details.)			21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason,
٧		16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occured.)		V	and type of discharge whether honorable, other than honorable, f fitness or unsuitability.)
		 Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) 		V	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, w.
ertify	that	I have reviewed the foregoing information supplied by me and that it is truitals, or clinics mentioned above to furnish the Government assembly the first true to the contract of the contract	e and con	nnlets	to the best of my knowledge. I subscribe
tors	hosp	pitals, or clinics mentioned above to furnish the Government a complete trans	nscript of	my n	nedical record.
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J.S. Department of Justice

Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

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7.	HAVE	YOU E	VER (Please check each item)					8.	DO Y	OU (Plea	ase check each item)
YES	NO		(0	heck e	each	item)			s No		(Check each item)
	X	Lived	with anyone who had tuberculosis					1-	Tx	Wear g	lasses or contact lenses
	X	Cough	ed up blood					†	×		ision in both eyes
	X.	Bled ex	ccessively after injury or tooth ext	raction	1					·	hearing aid
	×		ted suicide						1	Stutter	or stammer habitually
	X	<u>' </u>	sleepwalker						1	Wear a	brace or back support
9. 1	IAVE	YOU E	VER HAD OR HAVE YOU NOV	V (Ple	ase c	heck at l	eft of each item)		7	,	
YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
	X		Scarlet fever		X		Adverse reaction to serum drug		X		Epilepsy or fits
	<u> </u>		Rheumatic fever	 	Ϋ́,		or medicine		V		Car, train, sea or air sickness
			Swollen or painful joints	ļ	\^^		Broken bones	L.	X		Frequent trouble sleeping
	~ ·		Frequent or severe headache	-	~ "		Tumor, growth, cyst, cancer	<u> </u>	X		Depression or excessive worry
	7/		Dizziness or fainting spells				Rupture/hernia		V		Loss of memory or amnesia
	X		Eye trouble	ļ	\rightarrow		Piles or rectal disease		X		Nervous trouble of any sort
	X		Ear, nose, or throat trouble	<u> </u>	5		Frequent or painful urination		V	,	Periods of unconsciousness
	X		Hearing loss	ļ <u>.</u>			Bed wetting since age 12		J		Have you ever had
	7		Chronic or frequent colds	ļ	**. _{1.}		Kidney stone or blood in urine		\triangle		homosexual contact?
	Y		Severe tooth or gum trouble		<.		Sugar or albumin in urine	L		<u> </u>	Been exposed to AIDS
	·/ •<		Sinusitis	×.			VD-Syphilis, gonorrhea, etc.	<u> </u>	ļ		Alcohol Use (Excessive)
			Hay Fever		¥		Recent gain or loss of weight		*:		Drug Use/Addiction
	-		Head injury Skin diseases	ļ	4		Arthritis, Rheumatism, or Bursitis	<u>\</u>	1		Marijuana
	4		Thyroid trouble		~ /		Bone, joint or other deformity				Cocaine
\dashv	-`-		Tuberculosis		*\f		Lameness				Heroin
-	•		Asthma				Loss of finger or toe Painful or "Trick"shoulder or elbow		*/		L.S.D.
			Shortness of breath		1		Recurrent back pain		• , "	-	Amphetamines
	-		Pain or pressure in chest				"Trick" or locked knee				Others: (Specify)
			Chronic cough		. ·		Foot trouble				Alcohol or drug
	7		Palpitation or pounding heart				Neuritis	ļ	1		<u> </u>
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			High or low blood pressure		* hou		r draysis (include thranche)		.	-	
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i i			Stomach, liver, or intestinal trouble				11 Maria	~~	j-		Had a change in menstrual pattern
7			Gall bladder trouble or gallstones		\dashv						ARE YOU PREGNANT
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									Right	handed	☐ Left handed 000013

		CHECK EACH ITEM YES JEVERY ITEM CHECKED	YES M	UST E	E FULLY E. NED IN BLANK SPACE BELOW
YES	NO	No. 1	YES	1	
	V	Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		X	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
	1	B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other
	V	C. Inability to assume certain positions.		X	than minor illnesses? (If yes, give complete address of doctor, hospiclinic, and details.)
	X	D. Other medical reasons (If yes, give reasons.)			20. Have you ever been rejected for military service because of
	X	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).		X	physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
	\leq	15. Have you ever been denied life insurance? (If yes, state reason and give details.)		,	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and time of discharge whether have the service of the s
	\times	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occured.)		X	and type of discharge whether honorable, other than honorable, for fitness or unsuitability.)
j.		17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)		X	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.
certi	fy tha	at I have reviewed the foregoing information supplied by me and that it is true spitals, or clinics mentioned above to furnish the Government a complete trans	and con	nplete my m	to the best of my knowledge. I authorize any of the edical record.
		PRINTED NAME OF EXAMINEE	SIGN	IATU	RE 4
		meterns Beau a		\mathcal{A}	Temetine Brown
		ECEIVED FROM: COURT TRANSFER P.V	TH OR	ERE ALC	BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OHOL?
THE	R			DEC D	ATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL
		STAFF'S COMMENTS AND OBSERVATIONS: PLEASE			YES NO X
PPE/	ARAN	OUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, ICE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES,	WI	IAT A	RRANGEMENTS HAVE BEEN MADE?
		, BRUISES AND/OR MARKS, SWEATING, BODY DEFORM- C. NOTE OBSERVATIONS IN BLOCK 23 BELOW.		TV 6	FATHS, TEMPORARY WORK PROTECTED
DR	UGS	HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH,			TATUS: TEMPORARY WORK RESTRICTED L POPULATION YES NO
		EN, HOW USED. WHEN WERE THEY LAST USED: HAVE			ND EXTENT OF LIMITATION
. Pli an	ysicia y addi	n's summary and elaboration of all pertinent data (Physician shall comment or itional medical history he deems important, and record any significant findings	all pos here.)	itive a	nswers in item 6 through 22. Physician may develop by interview
					000014
		PROPER NAME OF PHYSICIAN OR DATEJULL 1 9 SOUTH			

Federal Bureau Of Prisons

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	(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTI, IL USE ONLY AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)											
1.	LAST	NAME	FIRST NAME—MIDDLE NAME				2. REG					
1	7) (*									
1		NWK NEEDE	De Metrius EXAMINATION	I	· · ·	DATE O	F EXAMINATION 5. EXA	. <u>(</u> . MIN	2.7 	 C1D.	037 Cewis	BURC
3.	PURF	OSE OF	EXAMINATION					# TATTI				RVICES UNIT
		,	14			06/	30/97					G, PA 17837
6 9	TAT	EMENT	OF EXAMINEE'S PRESENT HE.	AT TE	LAN	D MEDI	CATIONS CURRENTLY USE:	D (F				
0	JIAI	LINCOLT	OF EXPRIMEDED FREDERIT TIE.				or the to conduct the conduction		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		acsenpiro.	of past history, if complaint arrace,
												e ⁰⁰⁰⁰
												COA
ļ		YOU E	VER (Please check each item)									nse check each item)
YES	NO		(Ch	еск е	ich i	tem)		-	YES	NO		(Check each item)
·	8	Lived v	with anyone who had tuberculosis				3 P	4.	·	8	_	asses or contact lenses
			ed up blood					_ .				sion in both eyes
		L	cessively after injury or tooth extra	ction				.			J	hearing aid
<u> </u>	and the same	L	ted suicide				, , , , , , , , , , , , , , , , , , , ,			SERVE OF STREET		or stammer habitually
	-		sleepwalker					<u> </u>			Twear a	brace or back support
	,		VER HAD OR HAVE YOU NOW	(Plea	SE C	,			Т		DONUT	
YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)		(ES	NO	DON'T KNOW	Check each nem)
	O STATE OF THE PARTY OF THE PAR		Scarlet fever				Adverse reaction to serum drug	_		_[_		Epilepsy or fits
	14		Rheumatic fever		_		or medicine	_		-		Car, train, sen or air sickness
			Swollen or painful joints		.		Broken bones					Frequent trouble sleeping
			Frequent or severe headache			Service Control	Tumor, growth, cyst, cancer			1	ļ	Depression or excessive worry
	Ц_		Dizziness or fainting spells		1		Rupture/hernia			1	<u></u>	Loss of memory or amnesia
			Eye trouble				Piles or rectal disease			\bot		Nervous trouble of any sort
			Ear, nose, or throat trouble		\perp		Frequent or painful urination			1		Periods of unconsciousness
			Hearing loss				Bed wetting since age 12			1		Have you ever had
			Chronic or frequent colds				Kidney stone or blood in urine			_		homosexual contact?
			Severe tooth or gum trouble	7	}		Sugar or albumin in urine				مسسد	Been exposed to AIDS
			Sinusitis	j.poor and			VD—Syphilis, gonorrhea, etc.			-		Alcohol Use (Excessive)
			Hay Fever		-		Recent gain or loss of weight		-	<i>Y</i>	<u> </u>	Drug Use/Addiction
			Head injury				Arthritis, Rheumatism, or Bursiti	is d			<u> </u>	Marijuuna
	-		Skin diseases				Bone, joint or other deformity		_	+	<u> </u>	Cocaine
	1		Thyroid trouble		1		Lameness			1	ļ	Heroin
	- Annual Control		Tuberculosis		_ _		Loss of finger or toe			-		L.S.D.
	0		Asthma		_		Painful or "Trick"shoulder or elbe	юw		\perp		Amphetamines
			Shortness of breath				Recurrent book pain			\downarrow	<u> </u>	Others: (Specify)
	_		Pain or pressure in chest		-		"Trick" or locked knee	-		Ť		
	_		Chronic cough		}		Foot trouble	\dashv				Alcohol or draig
	9		Palpitation or pounding heart		\perp		Neuritis					Withdrawal Problems
			Heart trouble		en (LEE)		Paralysis (include infantile)				-	
			High or low blood pressure	į.		· !		-			<u> </u>	
			Cramps in your legs						0. F	EM.	ALES ON	Page county for a formula disorder
			Frequent indigestion	- 1				$-\downarrow$			 	Been treated for a female disorder
<u></u>			Stomach, liver, or intestmal gouble									Had a change in menstrual pattern
	-		Gall bladder trouble or gallstones								1	ARE YOU PREGNANT
			Jaundice or hepatitis					-			1	SUSPECT YOU ARE PREGNANT
11. 3	WHA	T IS YO	UR USUAL OCCUPATION?					ţ	19	F	YOU (Ch	13494494 C
			The Control of the Co							Rigl	ht handed	Left handed

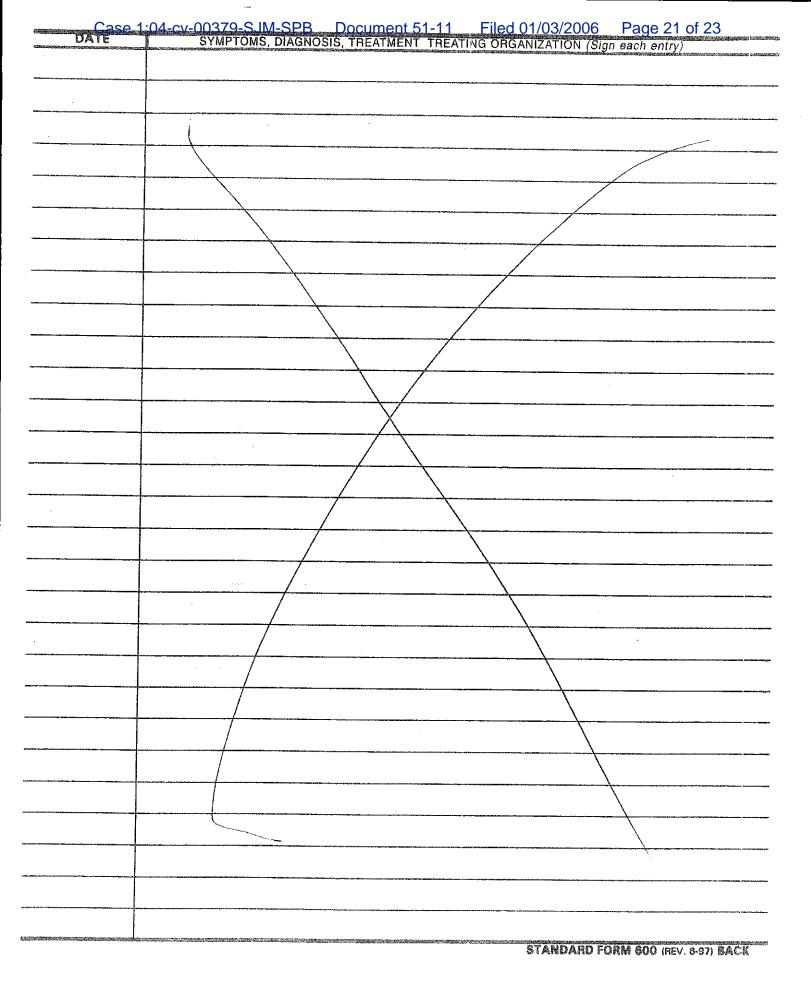
	CHECK EACH ITEM YE NO EVERY ITEM CHECKED	YES M	UST E	BE FULLY AINED IN BLANK SPACE BELOW
YES		YES	NO	
	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.		1	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)
	B. Inability to perform certain motions.	1		19. Have you consulted or been freated by clinics, physicians,
,	C. Inability to assume certain positions.			healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospin
,	D. Other medical reasons (If yes. give reasons.)	_	*	clinic, and details.)
1	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).			 Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
ě	15. Have you ever been denied life insurance? (If yes, state reason and give details.)			21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason,
1	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occured.)			and type of discharge whether honorable, other than honorable, for u fitness or unsuitability.)
	17. Have you ever been a patient in any type of hospital? If yes, specify when, where, why, and name of doctor and complete address of hospital.)		1	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
certify octors.	that I have reviewed the foregoing information supplied by me and that it is true hospitals, or clinics mentioned above to furnish the Government a complete trans	and con script of	plete i	to the best of my knowledge. I authorize any of the edical record.
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All Me Ev Hx	edications ergies Ves No No No No Idence of Lice Of IV Drug Use Icidal Thoughts Yes No N			
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REVERSE

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HEALTH RECORD		CHRONOLOG	ICAL RECORD OF MED	OICAL CABE	
D/.TE	SYMPTO		TMENT, TREATING ORGANIZ		
3/1/05		HANDLER'S EXAN			
1930	S) Any symptom	s or history of:			
	1: Acuté or	chronic inflammatory co	nditions of the respiratory sys	tem (active TB, cough, etc)	?
	Yes	Z No			
	2: Acute or a	chronic infections, skin c	liseases, open sores?		
	☐ Yes	No			
		hronic inPestinal infectio	os (diarrhea, etc.)?		
	☐ Yes	No No	ns (ularrisea, etc.);		
		No. 10 Company of the		,	
			Hepatitis B, Hepatitis C, etc.)	?	
	□ Yes	D'No			
	Explain any yes	answer to the above qu	estions:		
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		an see			
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(O) Blood Pressure:	110/18	Pulse: (pc Wt 1	90 Temp: 94	
	Pertinent, exam	including: ENT, lungs, l	neart, abdomen and skin. W		
No. of the second secon	**************************************			^	
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	" swaring	mare			
	(100)		·	D. J. b. l.	······································
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			William A Company of the Company of	/	
				D. Marini, M.D.	
S Anna		-		D. Winical V.	
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		PATENT'S NAME (Last, FI		SEX	
		RELATIONSHIP TO SPONS	Demetrius OR STATUS	RANK G	BADE
		SPONSOR'S NAME		ORGANIZATION	
			Churchtica tan na		~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~
	-	DEPART./SERVICE S	SM/IDENTIFICATION NO. 1634-03	1 OOC	0017

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NSN 7540-00-634-4176	AUTHORIZED FOR LOCAL REPRODUCTION
MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTONS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
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	lee Farm Alg Por Robert E. Piotrowski, PA-C
	Bally, PA-c FCI McKean
7/9/03 6	Unis, Note - PPD dose 7/8/03
0820m -	Remoting Pending heart. 7/10/6
	Mother PA-C
	Robert E. Plotrowski, PA-C FGI McKean
	FCI McKean
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IOSPITAL OR MEDICAL FACILI	STATUS DEPART./SERVICE RECORDS MAINTAINED AT FCI McKean
PONSOR'S NAME	SSN/ID NO. RELATIONSHIP TO SPONSOR
ATIENT'S IDENTIFICATION: (i De	For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; REGISTER NO. 4-03 7 WARD NO. te of Birth; Rank/Grade.)

Brown, Demetrics 21534-039

CHRONOLOGICAL RECORD OF IVIEDICAL CARE

Medical Record

STANDARD FORM 600 (REV. 6-000021 Prescribed by GSA/ICMR FIRMR (41 CFR) 201-9.202-1

